

بسم الله الرحمن الرحيم

الحمد لله رب العالمين والصلاة والسلام على أشرف المرسلين سيدنا محمد صلى الله عليه وعلى آله وصحبه وسلم ثم أما بعد

قال رسول الله صلى الله عليه وسلم

نضر الله امرا سمع منا حديثا فبلغه غيره ، فرب حامل فقه إلى من هو أفقه منه ، و رب حامل فقه ليس بفقيه ، ثلاث لا يغفل عليهن قلب مسلم : إخلاص العمل لله ، و مناصرة الأوامر ، و لزوم الجماعة ؛ فإن دعوتهم تحيط من ورائهم و من كانت الدنيا نيته فرق الله عليه أمره ، و جعل فقره بين عينيه ، و لم يأت من الدنيا إلا ما كتب له ، و من كانت الآخرة نيته جمع الله أمره ، و جعل غناه في قلبه ، و أتته الدنيا و هي راغمة

الراوي : زيد بن ثابت - المحدث : الألباني - المصدر : صحيح الترغيب - خلاصة حكم المحدث : صحيح

أول حاجة شيت الكارديولوجي

Cardiology (long case)

A. History

Personal history

Mr. xxxx 41 years old, from Giza, driver, married 21 years ago and has 3 daughters, the youngest is 2 years old, he is moderate smoker.

- **He is complaining of:** shortening of breathing of 1 week duration.
- **History of present illness:** patient was quiet well until he suffered from an exertional dyspnea of gradual onset and progressive course with 10 years duration.

This dyspnea increased by exercise and decreased by rest, treated by digoxin but recurrent, No orthopnea or P.N.D.

No cough, haemoptysis or recurrent chest infection.

- 3 years later he developed regular palpitation of gradual onset and progressive course, increased by exercise & decreased by rest.
- 2 months ago palpitation became irregular without precipitating or relieving factors.
- No symptoms of systemic venous congestion.
- No cyanosis, no symptoms of low cardiac output or syncope.
- No chest pain, pressure manifestations, B.P. changes, fever or embolic manifestations.
- No symptoms of other systems affection.
- Patient investigated by E.C.G., chest X-ray, Echo cardiography and Doppler and treated by digoxin, marivan and lasilacton.
- **Past history** of rheumatic fever at age of 7, manifested by fever, polyarthritis and skin rash, investigated by blood analysis and treated by aspirin long acting penicillin every month without compliance.
 - No history of surgical operation, allergy, or drugs intake.
- Irrelevant family history.

VISIT...

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B. General examination

1. Patient with an average general condition.
2. Mentality: patient is fully conscious, oriented by time, place and persons, with good mood and memory; he is co-operative with an average inelegancy.
3. Average built.
4. Patient lies comfortable in bed.
5. Face:
 - Body temperature = 37.1 °C.
 - No pallor, jaundice or cyanosis.
6. Neck:
 - Not congested neck veins.
 - Normal carotid pulsation.
 - Central trachea.
 - No thyroid or lymph node enlargement.
7. Upper limbs:
 - Pulse: 85 beats / min., irregular, variable volume, equal in both sides, pulse deficit > 10 / min., condition of blood vessels are normal with palpable dorsalis pedis.
 - Blood pressure = 110 / 70.
 - No hand clubbing.
8. Lower limbs:
 - No lower limb edema.
 - Intact peripheral pulsations.

a. Local examination

Inspection:

- No precordial bulge.
- No scars.
- No dilated vein or pigmentations.
- Visible apical pulsation.

Palpation:

- Apex
 - ✓ Site: left 5th I.C. / M.C.L.
 - ✓ Area: localized.
 - ✓ Character: hyper dynamic.
 - ✓ Thrill: systolic thrill.

Percussion:

- Hepatic dullness in 5th I.C. space.
- No dullness outside right border of the heart.
- No dullness on base of the heart.
- No dullness outside the apex.
- No sternal dullness.

Auscultation:

- Apex

- ✓ Variable S_1 .
- ✓ Murmur:
 - Pansystolic.
 - Soft.
 - On apex.
 - Propagated to axilla.
 - ↑↑ by exercise.
- Tricuspid
 - ✓ Variable S_1 .
 - ✓ No murmur.
- Base
 - ✓ Normal S_2 .
 - ✓ No murmur.

No additional sounds or crepitation.

Diagnosis

A case of rheumatic valvular heart disease, most probably M.S. & M.R.
Patient is compensated but complicated by A.F.

Chest (long case)

A. History

Personal history

Mr. Muhammad Ahmad 74 years old, married and has 3 children, the youngest is 26 years old, he is a waiter, from Imbaba, he is a heavy smoker.

Complaint

Patient is complaining of shortening of breathing and chest wheezes of 3 days duration.

Present history

The condition started 30 years ago by gradual onset and progressive course of **cough**, especially at early morning and winter time, increased by exertion, decreased by rest, associated with **expectoration of sputum** which was; scanty, whitish, thick, not foetid and had no special character. The expectoration used to increase in the early morning and winter time, but: there was no postural variations.

Two years later, the patient started to suffer from exertional **dyspnea**, with gradual onset & progressive course, increased by exertion, decreased by rest, not associated with orthopnea or PND, but: it was associated with persistent **wheeze**.

Patient sought medical advice and was admitted to Demirdash hospital where some investigations were done to him in the form of chest X-ray, sputum analysis which was negative, in addition to the usual routine laboratory work-up.

He received bronchodilators (Aminophylline) by infusion, cortisone, antibiotics (Flumox), oxygen inhalation and doses of bronchodilators by nebulizer when needed. He received this medication for 2 weeks till his condition was stabilized & was then discharged.

His condition partially improved, but he used to suffer from repeated attacks of severe dyspnea and wheezes improved by received his usual regular medication.

Six years later, the patient started to suffer from gradual persistent dull aching **pain** in his right hypochondrium increasing by meals & by exertion associated with **oedema** of his lower limbs but with no ascites. He sought medical advice again where diuretics (lasix) were added to his usual medication & was advised proper bed rest. The oedema disappeared & the pain partially improved & his condition is stationary as such up till now.

There was no haemoptysis, no cyanosis, no compression symptoms, no symptoms of T.B. toxemia & no symptoms of respiratory failure. There were no symptoms of other systems affection.

Past history

There is no past history of DM, hypertension, T.B., allergy, Bilharziasis. There is no past history of previous operations, or blood transfusion.

Family history

Family history is irrelevant.

Diagnosis

A case of bilateral lung disease most probably COPD due to chronic irritation, the patient compensated and complicated by cor-pulmonale.

B. General examination

- The patient with an average general condition, fully conscious, oriented by time, place and persons, with good mood and memory, co-operative with an average intelligency.
- The patient with an average built for his age, he lies comfortable in bed.
- No pallor, jaundice or cyanosis.
- Respiratory rate
 - ✓ Tachypnea with working accessory respiratory muscles.
- Head examination
 - ✓ Puffiness of the eye lid due to chronic cough.
- Neck examination
 - ✓ Congested neck veins due to: increased intrathoracic pressure, or cor-pulmonale.
- Upper limbs examination
 - ✓ **Pulse:** 80 beats / min., regular, variable volume, equal in both sides, pulsus paradoxicus > 15 mmHg. (marked drop of systolic pulse during inspiration).
 - ✓ **Blood pressure:** 110 / 75 mmHg.
 - ✓ No hand clubbing.
- Lower limbs examination
 - ✓ Oedema of lower limbs (cor-pulmonale or less commonly salt and water retention).
- Abdominal examination (not in this patient)
 - ✓ Lower border of the liver may be displaced downwards due to (ptosed liver by flat diaphragm or enlarged liver due to cor-pulmonale).
 - ✓ Umbilical or inguinal hernia may be present as a complication of chronic cough.
 - ✓ No ascites (only if RSHF occurred).
- Cardiovascular examination
 - ✓ Absent apex (emphysema).
 - ✓ Faint heart sounds.

C. Local examination

Inspection

Shape of the chest

- Barrel shaped chest (emphysematous) with increased anteroposterior diameter.
- Relatively low-lying diaphragm.
- No scars, dilated veins or pigmentation.
- There is epigastric pulsation & left para sternal pulsation. (right ventricle enlargement).

Respiratory movement

- Diminished bilaterally.
- Mainly abdominal respiration.
- Suction of supra clavicular , supra sternal & lower intercostals spaces during inspiration and fullness during expiration.

Palpation (5 T)

- Central **t**rachea.
- No **t**enderness.
- **T.V.F.:** equal on both sides (diminished all over the chest).
- There is palpable **w**heezes with deep respiration.
- Bilateral limitation of chest **e**xpansion.

Percussion

- Hyper-resonance all over the chest.
- Encroachment on the normal hepatic & cardiac dullness.

Auscultation

- Diminished air entry.
- Vesicular breath sounds with prolonged expiration.
- Generalized wheezes (diffuse, mainly expiratory, polyphonic, changes with cough).
- Crepitation: early inspiratory (opening snap of the chest).
- No vocal resonance.

Abdomen (long case)

A. History

Personal history

Female patient, xxx, 47 years old, from Al-Fayoum, house wife, married 29 years ago and has 3 sons, the youngest is 19 years old, she has no special habits of medical importance.

Complaint

She is complaining of abdominal swelling of 2 weeks.

History of present illness

The condition started 15 years ago by an active attack of haematemesis of sudden onset with 2 cups of dark brown blood preceded by nausea and followed by melena for 3 days, she admitted in Aldemerdash hospital, investigated by upper endoscopy & treated by endoscopic sclerotherapy without blood transfusion and this attack is not recurrent until now.

- No appetite changes, dysphagia, heart burn or halitosis.
- No changes in bowel habits or bleeding per rectum.
- 10 years ago, patient suffered from lower limbs oedema with gradual onset and progressive course, responds to diuretics.
- Followed after 2 years by ascites with gradual onset and progressive course with several paracentesis process of about 3 liters of clear fluid and not followed by any complications.
- Lower limb oedema & ascites are associated with jaundice and pruritis with dark urine and low grade fever & progressive mild loss of weight.
- No abdominal pain or urinary symptoms.
- No gynaecological symptoms.
- No symptoms of other system affection.
- Patient is investigated by CBC, liver function tests and abdominal ultrasonography then treated by vitamins & diuretics.

Past history

History of bilharziasis at age of 13, manifested by dysentery, investigated by urine & stool analysis and treated by praziquantil.

- No history of other chronic diseases, surgical operations or drug intake.

Family history

Irrelevant.

B. General examination (very important)

- Patient with an average general condition, average built.
- Patient is fully conscious, oriented for time, place and persons
- Patient lies in semi sitting position.

Head and face examination

- Orange yellow jaundice, wasted temporalis, with endemic parotitis.
- No pallor or cyanosis.
- No puffy eyelids with normal eye brows.
- Bad oral hygiene with normal tongue size.

Neck examination

- Congested pulsating neck veins, JVP = 4 cm above sternal angle with normal waves.
- Palpable carotid pulsation without thrill.
- Central trachea - no lymph node enlargement or thyroid swelling.
- Spider nevus in root of the neck.

Upper limb examination

- **Pulse:** 75 beats / minute, regular, big volume,
- **Blood pressure:** 130 / 50 mmHg.
- **Palmar erythema:** are present in both hands.

Lower limbs examination

- Shows bilateral, painless, pitting oedema.
- **Echymotic patches:** are present in lower limbs, upper limbs and trunk.
- **Systems examination:** no abnormalities were detected are regard C.V.S., chest & C.N.S. examination.

C. Local abdominal examination

Inspection

- Symmetrical enlargement of the abdomen with full flanks, wide subcostal angle, and abdomen moves freely with respiration.
- No gynecomastia, epigastric pulsation.
- There are divercation of recti, umbilicus is shifted downward, everted with umbilical hernia, no pigmentation, discharge or nodules.
- No stria, scan other hernia or dilated veins.
- No swelling in renal angle or back deformity.

Palpation

A. Superficial

- No superficial swelling or tenderness.

B. Deep palpation

- Right & lower lobes of liver are not palpable.
- Spleen: swelling in the left hypochondrium intra-abdominal, 5 fingers below the left costal margin with notch, sharp edge firm in consistency, smooth surface, not tender & not pulsating.
- Kidney are not palpable.
- No any palpable mass.

Percussion

- Moderate ascites is detected by shifting dullness.
- Dullness on Traub's area.

Auscultation

- Normal intestinal sounds.
- No vascular sounds, rubs or splachs.

Diagnosis

A case of shrunked liver with splenomegaly for D.D. most propably due to mixed bilharzial & hepatitis cirrhosis, with vascular and cellular decompensation.

Neurology (long case)

1. History

Personal history

Mr., 70 years old, driver, married and has 4 children, the youngest is 26 year old, from Hadayik Elqoba. He is a heavy smoker and right handed.

Complaint

Patient is complaining of: weakness in the left upper & lower limbs of 24 years duration.

Present history

The condition started 24 years ago by sudden onset and regressive course of weakness of the left upper and lower limbs, the muscles were flaccid for 4 weeks then became stiff with weakness more distal than proximal, abductors than adductors, flexors than extensors in lower limbs and extensors than flexors in upper limb, there is no wasting, fasciculation or trophic changes. There is no involuntary movements or inco-ordination.

From the onset of the disease, there is accumulation of food in left side, deviation of mouth to right side, deviation of tongue to left side, no dripping of saliva. There is dropping of left shoulder and no other cranial nerves affection.

There is speech troubles with the onset of the disease, but improved after 2 months. There is hemihyposthesia in left side of the body and upper & lower parts of the face. The patient feels as he is walking on a cotton on left side.

The patient denied that there is no sphincteric troubles. There is no hypothalamic manifestations, no symptoms of increase ICT, no coma, no convulsion, no fever.

The patient used to suffer manifestations of systemic hypertension which is controlled by β - blockers. There is no other system affection.

Past history

Hypertension controlled by β - blockers, no other diseases.

Family history

Family history is irrelevant.

Diagnosis

A case of organic spastic left side capsular hemiplegia due to thrombosis secondary to hypertension (atherosclerosis).

2. General examination

- The patient with an average general condition, fully conscious, oriented by time, place and persons, with good mood and memory, co-operative with an average intelligency.
- The patient with an average built for his age, he lies comfortable in bed, no pallor, jaundice or cyanosis, no characteristic facies of medical important.
- **Respiratory rate:** 17 / min, **pulse:** 85 beats / min. regular, equal in both sides, **temperature:** 37.7° C. **blood pressure:** 140 / 90 mmHg (hypertension).
- **Head examination:** no ptosis, oedema or subconjunctival hemorrhage, there is deviation of mouth to right side & deviation of tongue to left side.
- **Neck examination:** no congested neck veins, regular carotid pulsation and no lymph nodes enlargement.
- **Upper limbs:** there is no tremors, deformities or clubbig.
- **Lower limb:** there is no oedema or clubbing.
- **Cardiovascular examination:** elevated BP, signs of left ventricular enlargement with heavig apex, accentuated 1st and 2nd heart sounds with ejection click. (systemic hypertension).
- No abnormality detected in **other systems**.

3. Neurological examination

1. **Speech:** no speech troubles.
2. **Cranial nerves:**
 - **I** : no abnormality detected.
 - **II** : visual acuity & visual field: no abnormality detected.
intact light and accommodation reflex.
 - **III, IV & VI** :
inspection: no ptosis, no squint, pupil: regular, round, reactive to light & accommodation, equal in both sides. No nystagmus.
power: the patient can move each eye separately and both eyes together in all direction. No abnormality detected.
 - **V** :
inspection: no hollowness above or below zygoma.
power: muscles of mastication & pterygoids act normally.
reflexes: absent jaw reflex & intact corneal reflex.
sensation: loss of sensation in left half of the face (upper & lower parts + area supply by C2).
 - **VII** :
inspection: left side: intact wrinkles of forehead, absent nasolabial fold, deviation of mouth to right side & no dripping of saliva.
power: upper part normal, patient can elevate his eye brow & close his eyes. Lower part paralyzed (weak orbicularis oris on smiling) indicated that contralateral lower facial nerve affection.
 - **VIII** : no abnormality detected.
 - **IX & X** :
normal uvula elvation
intact gag & pharyngeal reflex.

- **Spinal part of accessory:**
inspection: dropping of left shoulder.
power: the patient can't elevate his left shoulder against resistance.
- **Hypoglossal nerve:** tongue: no wasting & fasciculation. The tongue deviated to left side.

There is contralateral cranial nerves affection (lower facial - hypoglossal - spinal part of accessory).

3. **Motor system:**

- **Inspection :** there is semi-flexed left upper limb and hyper extended left lower limb, no muscles wasting, no deformity, no trophic changes.
- **Palpation:** there is hypertonia of left side of the body clasp knife type affects antigravity more than progravity muscles.
- **Percussion:** there is no fasciculation or myotonia.
- **Power:** there is paralysis (weakness) of left side of the body affects progravity more than antigravity and distal more than proximal muscles.

4. **Reflexes:**

- Planter reflex: positive Babinski sign.
- Abdominal reflex: lost on left side.
- Exaggerated deep reflexes in left upper and lower limbs.
- Pathological reflexes appear on left side: (Hoffman - wartenburg - finger reflex - patellar reflex - adductor reflex).
- Loss of superficial reflexes in left side of the body.
- Ankle, patellar & wrist clonus are presented.

5. **Sensory system:**

There is hemihypoesthesia on the left side of the body, loss of deep sensation on left side & normal cortical sensation on right side (not examined on left side).

- 6. **Back:** there is no scars, deformity or tenderness.
- 7. **Gait:** the patient has left circumduction gait. (Hemiplegia gait).

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المهم أن المعلومة توصل لغيرك

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اللهم اجعل عملنا خالصاً لوجهك الكريم

اللهم آمين

😊 سلام بقا